

Saratoga County Office for the Aging
152 West High Street, Ballston Spa NY 12020
518-884-4100
Fax:518-884-4104

Appointment Date: _____ Time: _____

HIICAP Intake Form

Health Insurance Information, Counseling, and Assistance Program

Kindly return this completed form to the address above before your appointment.

*Please note: If the information you submit is incomplete or incorrect,
the HIICAP Counselor is not responsible for any subsequent insurance coverage difficulties.
Please print or write clearly in blue or black ink. Thank you.*

Name _____ Date of Birth _____ Age _____
Mailing Address _____ Zip _____
Physical Address _____ Zip _____

Phone: _____
Home _____ Marital Status: Married [] Single []
Veteran: Yes [] No []

Social Security No. _____ Medicare No. including letter from card: _____
____ - ____ - ____ - ____ - ____ - ____

Monthly Income and Source: _____ Medicare effective dates from card:
_____ HOSPITAL (PART A) ____ / ____ / ____
_____ MEDICAL (PART B) ____ / ____ / ____

Are you a member of EPIC? Yes No EPIC ID# _____
Active _____
Pending _____
Extra Help (Low Income Subsidy) Yes No Spend down _____

Medicare Part D Plan Supplemental Insurance Plan
Name _____ Name _____
Phone _____ Phone _____
Member No. _____ Member No. _____

Medicare Advantage Plan Employer/Retiree Insurance Plan
Name _____ Name _____
Phone _____ Phone _____
Member No. _____ Member No. _____

Prescription Medications

List **all** prescription drugs. Please print or write clearly in blue or black ink. See example below.

<u>Drug Name</u>	<u>Dosage (mg/mcg)</u>	<u>Frequency</u>	<u>Taken For</u>
Example: <u>Simvastatin (generic for Zocor)</u>	<u>25 mg</u>	<u>one/day</u>	<u>cholesterol</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10 _____	_____	_____	_____
11 _____	_____	_____	_____
12 _____	_____	_____	_____
13 _____	_____	_____	_____
14 _____	_____	_____	_____
15 _____	_____	_____	_____

Please list the pharmacies you use and where they are located.

Pharmacy name _____ Address _____

Pharmacy name _____ Address _____

Authorization to Release Information

I am the individual to whom the information/record pertains, or am authorized to consent, on behalf of the individual, to the release of the information/record. I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison or both. I, _____ give permission to Saratoga County Office for the Aging Health Insurance Information Counseling and Assistance Program (HIICAP) to share any and all information needed to assist with Medicare issues.

Signature: _____

Date: _____

For Office Use Only Website: www.medicare.gov

Data entry by _____ Date _____

Drug List # _____ Password Date _____